Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Relieving Emergency Department Burden During COVID-19: Section 1135 Waivers for Dental Case Diversion

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Many hospital emergency departments (EDs) are currently overburdened with evaluation and management of coronavirus disease-2019 (COVID-19) cases. Dental emergencies, generally attributed to infection or trauma, are costly and inefficiently managed in the ED setting, yet remain in the caseload. In addition, given the current scarcity of personal protective equipment, staff, and operating rooms, patients who present to EDs with dental pain would be best suited to be immediately referred to an independent dental office. Although current law mandates the evaluation of all patients who present to the ED, legislative carve outs made possible by recent US executive branch national emergency declarations make it possible for hospitals to immediately divert patients with dental pain to partnering dental offices and relieve valuable time and resources for EDs to direct their efforts at stemming COVID-19.

In 2016, 2.2 million patients visited hospital EDs for dental pain at a cost of $2.4 billion; 2% of all annual ED visits in the United States are of dental origin.[1] Of those, 90% of patients do not receive the dental procedure they require in the ED, resulting in inadequate treatment at a higher cost relative to restorative dental care, additional burden on ED staff, and an increased likelihood of return to the ED for recurrent pain. Dental ED visits also present a high financial burden to patients. Data from the Texas Health Institute estimate the ED cost of a nontraumatic dental complaint averaged $1,843 per visit, with admissions costing the state $46,198 per admission.[2] In comparison, the American Dental Association estimates the average cost of an emergency visit in an independent dental office to be between $90 and $200.

Patients presenting to the EDs also risk nosocomial infection from droplet-borne and aerosolized viral particles. COVID-19 is particularly virulent, and indirect exposure in crowded EDs increases the likelihood of transmission. Redirecting dental emergency patients to local dental offices may reduce the number of individuals unnecessarily exposed to SARS-CoV-2 and community spread.

The American Dental Association estimates that 79% of all dental-related emergency department visits could be immediately diverted to a dental office.[3] Pilot programs have demonstrated that emergency department diversion programs reduce dental-related ED visits. A program at Virginia Commonwealth University diverted patients from the ED to a dedicated urgent dental care clinic within the hospital's oral and maxillofacial surgery department.[4] As a result, dental-related ED visits declined more than 52% during the first year of the program and return visits to the ED dropped by 66%. However, most hospitals do not have dedicated departments of hospital dentistry or oral and maxillofacial surgery and depend on external dental clinics to deliver dental care to their patients. Current federal policies require emergency patients to be evaluated in the ED before discharge or referral to local dental offices owing to the Emergency Medical Treatment and Labor Act (EMTALA). During a viral epidemic, strained ED resources indicate need for policy action to streamline and prioritize more emergent needs.

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Hospitals have very low collection rates from patients who present with dental pain to the ED. One study found that compensation rates for ED physician fees for dental-related care was only 9.8% and compensation rates for hospital fees were only 16%.[5] In addition, owing to COVID-19–related social distancing measures, recommendations by state dental boards, and public fear of infection, most independent dental practices have scaled back operations by reducing work hours and, at best, offering minimal emergency services. This is likely to increase the number of patients who present to EDs with dental pain.

The increased financial stress on private dental offices during this time, along with the low collection rates for dental-related care by hospital EDs, offers a compelling justification for a financial arrangement wherein hospitals refer and pay for the evaluation and definitive treatment of emergency dental patients at local dental practices. Definitive treatment in the dental office also prevents patients from making recurrent ED visits for unresolved dental pain. Such an arrangement both financially and logistically benefits hospitals by opening up ED beds to care for patients with medical conditions, including individuals with COVID-19.

Under EMTALA, physicians must stabilize, evaluate, and treat any patient who presents to the ED. However, policies invoked during the time of a global pandemic have made diversion of dental cases to independent dental practices possible without the need to use scarce emergency department time and resources. The US President's emergency declarations under the Stafford Act and the National Emergencies Act, when coupled with the Health and Human Services Secretary declaration of a public health emergency under Section 319 of the Public Health Service Act, allow for a temporarily waiving of EMTALA via a Section 1135 waiver under the Social Security Act. This waiver allows hospital emergency departments to divert patients presenting with a chief complaint of dental pain to designated independent dental offices without the requirement to evaluate and manage them in the ED.

Hospitals with an existing department of hospital dentistry or department of oral and maxillofacial surgery can simply make arrangements to redirect their patients to their outpatient facilities. Hospitals without the aforementioned departments can contract with local dental practices, dental schools, and/or community health centers to serve as an ancillary provider of emergency dental care for patients who present to the hospital ED. Partnering practices would be reimbursed per dental service at equal to or higher than state Medicaid rates. If a state's Medicaid program does not cover dental care, the price per service may be pegged to the Medicaid national average rate. The number of contracted practices associated with each hospital may depend on demand and the historical volume of emergency department visits for dental pain. To serve patients who visit the ED after hours, approximately 70% of all dental-related ED visits,[3] emergency departments may implement a call schedule for partnering dentists to see patients who require immediate dental care.

In the event a patient presents with both dental pain and systemic illness, such as fever or lethargy, the patient should be evaluated by the ED and assessed for any active systemic or infectious diseases before discharge to a locally contracted dentist. If the patient requires admission or monitoring, palliative dental care recommendations can be provided by the dentist through a phone call with a plan in place for follow-up care at the dental office.

This public health emergency challenges existing healthcare systems to provide quality care in the face of overwhelming patient volume. Current low hospital collection rates for inadequate dental-related care and financial stress on dental offices provide an opportunity for mutually beneficial partnerships between hospitals and local dental offices. A novel use of the Section 1135 waiver to immediately refer out dental care may open up valuable ED resources, while improving safety and quality of care.

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